

ICI Consumer Implementation Council
Monday March 28, 2016
Meeting Minutes
3:00 – 4:00pm

Attendees: Mary Ladd, Rhonda Schwartz, Linda Katz, Maureen Maigret, Marjorie Waters, Cristina Amedeo, Tammy Russo, Kathy Heren, Kathleen Kelly, Gretchen Bell, Anne Mulready, Suzanne Carson, Nancy Sitin, Bill Flynn, Nicholas Oliver, Virginia Burke, Jim Nyberg, Maria Fatima Barros, Michelle Szylin, Lauren Lapolla, Moise Bourdeau, Diana Beaton, Jennifer Bowdoin

- I. Welcome – Jennifer Bowdoin, EOHHS/Xerox
Jennifer Bowdoin: Welcome everyone to the meeting today. First thing on the agenda is the proposed rule, will hand out copies of the rule and can email it again if you have not yet received it in your inbox.
- II. Integrated Care Initiative Rule Discussion – Community Review
Jennifer Bowdoin: This is a proposed rule – re-written to bring in Phase II and to clean up the language in the rules. This is not the official proposed rule yet, we are not yet in an official public comment period, but there have been some criticisms in the past that EOHHS does not give adequate time for feedback so this initial discussion is designed to hear those criticisms and provide a chance for early comment. A prior version was handed out at an EOHHS Task Force meeting a month ago, so we did make some adjustments from those first comments. This is a clean version as the red-line version often is harder to read. I do not expect people to have read it and fully digested it, though happy to take any comments now. Let's orient what is in here, and then talk about comments and feedback. We will have an official public hearing about it, but if helpful we can schedule a meeting again in two weeks to put this back on the agenda before it officially becomes that proposed rule.

Jennifer Bowdoin: The structure is a high level overview of the rule. It is intended to cover the managed care option for beneficiaries that fall into the category of ABD adults. Not the rule for folks in expansion categories, these are the managed care options for those in the PACE program, and for ICI Phase I and Phase II.

Bill Flynn: The DD population, are they covered?

Jennifer Bowdoin: Yes they would be – which population vary a bit by characteristics, but in general yes.

Jennifer Bowdoin: The rule has the overview, definitional language, and then it is broken down into discrete sections beyond that. The first big section goes to ABD adults not enrolled in Medicare, and not receiving Long Term Services and Supports. The next big two sections apply to

Phase I and Phase II of ICI. PACE is included as a program option for certain population as, although we often are focused on the ICI we do talk about PACE as a program option. Within the specific subsections on the Rhody Health Options, on the ICI, there is information on the authority and scope, information on the populations eligible for those programs, information on enrollment and disenrollment, and the benefits provided within programs. Let me stop there and see if there are questions thus far.

Kathy Heren: In all of these plans one of the most essential things is missing – there are no dental services in any of these plans?

Jennifer Bowdoin: No, they are not in plan – they are FFS. It is covered by the Medicaid program, but not in these plans. Not the strongest part, but that's what it is.

Kathy Heren: If you are trying to keep people in the home, and nutrition is huge, then isn't dental key? Is it just that dentist's won't take Medicaid?

Jennifer Bowdoin: It is a bigger issue overall – access, reimbursement.

Marjorie Waters: From a community perspective it is nearly impossible to find a dentist that will take Medicaid. Thundermist does, but all of your health care ahs to be focused there.

Linda Katz: Medicaid dentist is a fairly limited scope of benefits. The bigger issue is the Medicaid payment for dental services so many do not take it. On the kids side, they created a dental managed care product so now kids can have their needs met. As it stands now, seniors and people with disabilities can access with their Medicaid card, but the whole dental for adults is a huge issue we need to deal with. One of the proposals five years ago to save money was to cut out dental services for the whole Medicaid populations.

Kathy Heren: I am surprised.

Virginia Burke: What we are saying here though is that this doesn't change any existing rules for dental services, it just keeps dental in the FFS world as it has been,

Jennifer Bowdoin: Yes dental is a problem that we should work on, yet there are no changes to the dental benefit hat come out of this proposed rule. We can put it on an upcoming agenda, and brainstorm from there.

Linda Katz: I am glad you gave the overview of who this was targeted to and I was confused about who this is addressing – there were some referenced to RlTe Care parents and Medicaid expansion so...

Jennifer Bowdoin: There are separate rules that deal with RlTe Care Parents and the MAGI group. By and large it doesn't affect them, but it is possible there is a parent or caretaker in the RlTeCare Parents program, or MAGI and it is a very small subset of that group who in theory could be considered dually eligible.

Linda Katz: OK should be clarified a bit more. Also, RHP doesn't provide descriptive services for level of care determinations to access LTS like

services. The list in the current rules for services had homemaker/ minor environmental modifications and respite, but I think the current list in here includes some but not all. For years now we have had people SSI enrolled in managed care through RHP. I believe that their list of benefits included the core preventive services without going through a LOC determination to get them. I do not think they are listed in here now, and I do not know if that is intentional or unintentional; we have also had questions from the on hold level of care rule as well. Trying to bring all the pieces together.

Jennifer Bowdoin: We will go back and check the benefit list; I believe Ann (Martino) took this from what is in the contract.

Linda Katz: What is in the contract may be different from the current regs.

Jennifer Bowdoin: Ok we will take it back.

Maureen Maigret: On page two you have a new definition for the Integrated Care Coverage group. I wasn't quite sure why you put the people in the Medicare Premium program in that category as it's a different eligibility.

Jennifer Bowdoin: We will go back and clarify. Ann did add some definitions in an attempt to clarify who is in and who is out, we will go back and check.

Maureen Maigret: On pg. four the definition of partial rule eligible plus, that too. Should resources be the term used here? Shouldn't it be income?

Jennifer Bowdoin: We will check that as well.

Maureen Maigret: Then Person Centered Planning – halfway down at the end it says in the most inclusive setting. What does that mean? Is it integrated?

Jennifer Bowdoin: We will clarify.

Linda Katz: It could be much clearer if there was just a description of the populations intended to be covered, who is not. A lot of the language repeated that is common to all of them could all just be in one place, and then if rules are specific to the RHP - it sounds like RHP, RHO, Medicaid Only and ICI Phase I and Phase II – I think streamlining it would be really helpful.

Maureen Maigret: Also are you going to have a new name? You have RHO and then for the phase II new name?

Jennifer Bowdoin: CMS did not like RHO Phase I and RHO Phase II. Within in the context of Phase II – the first phase is RHO. The second plan is the Medicare/Medicaid Plan. NHP is branding it as Integrity.

Diana Beaton: ICP II here is ICI Phase II, so Integrity. We need to streamline.

Jennifer Bowdoin: We will work on cleaning this up. It is a bit of a

challenge to get these things in way that we can all understand.

Linda Katz: I would be happy to participate in a work group to clean up some of the language if that is helpful. Also there is confusion around the interpreter passages here – translation services different than interpreter.

[Unidentified Commenter]: Under Phase I on pg 14 it describes Medicaid beneficiaries who have other forms of commercial coverage – are they already covered under RHO?

Jennifer Bowdoin: It does not exclude you. There may be other reasons that you may not have qualified.

Virginia Burke: I would be happy to join like Linda to help with a work group to make this more intelligible.

Linda Katz: Another issue for me is the definition for Person Centered Panning. Where in all of this is the old personal choice waiver and if people want to self direct their care.... It seems to be that is a big issue that should be explained in terms of the content of the benefits. Also there is the overlap with an article in the budget this year that expands the definition of managed care - I do not understand why that definition is there, and also I see that reflected in here. Are we saying everyone is in managed care?

Marjorie Waters: It sounds like try it you'll like it.

Jennifer Bowdoin: They could be a partial dual – just have Medicare Part A but not all Medicare. We do need to clean it up.

Diana Beaton: We did discuss in one of our consumer materials meetings how to map how they intersect, and who to really clarify language.

Maureen Maigret: I think an underlying issue for me is that there is still confusion in terms of the Long Term Services and Supports, as the list is very long, but people do not really understand. Eligible for Long Term Services and Supports, you look at this list – who is eligible to get some services and who is not. What is the extent of service that people can get in their homes?

Linda Katz: That goes back to the other set of regs – like the level of care proposed regs. Not clear to me the level of what you could get and what the scope was. Maybe that is another piece understanding the rules changes coming out. There is also the financial eligibility which is not a part of this at all. SO that, LOC, managed care rule, so many that overlap.

Michelle Szylin: This is the list of services that are in the 1115, though not all services apply to everyone. There are certain services that apply only to HAB, some only to personal choice. We look at them as a core set of services, but they are program specific.

Maureen Maigret: That is why it is so confusing – we are supposed to have one big waiver but there are different programs.

Linda Katz: Well, and that speaks to the underlying issue of what we all

thought the 1115 waiver would apply and mean, and then trying to lay those over one another.

Michelle Szylin: Things different for HAB than for everyone else in this list is private duty nursing- only they can get those, but also everything else on this list.

Jennifer Bowdoin: Let me ask a question – we will never be able to provide all the detail in here to describe how it operates. We can provide more information about what applies to whom, but we also do not want a 200 page rule. How would you like to see this?

Linda Katz: I think we have to see the regulations altogether. Financial eligibility, Level of Care, and then these to see how based on age or disability are engaged in a managed care environment. Then the regulations have to be consistent with each other rather than describing anyone in a HAB waiver there is hospital level of care, high and preventive. If we could see a chart that would describe those that would help. Preventive is the \$64,000 question.

Jennifer Bowdoin: We can try to add more detail about who qualifies for what.

Virginia Burke: Should we be doing this together, have input from us as you do that?

Jennifer Bowdoin: I am hesitating a little bit as it is hard to have a big group of people work and come together and be effective quickly. We may want to make some changes from these comments here.

Michelle Szylin: The plan applies for preventive level of care – it doesn't mean they cannot provide them while waiting, but it does apply. They are community eligible.

Virginia Burke: People who meet the highest need have an entitlement to choose their care in community vs. institution. High only have community. Is there a different range of services?

Michelle Szylin: No it is the same. Tighten it up on both sides. Nothing extra if highest at home.

Virginia Burke: At the last meeting Ann mentioned that we were tightening them up as we were the only state beside Vermont allowing Nursing Facilities level of care in their own home.

Michelle Szylin: Right so that is different that is a definition which is different than the way we talk about it. It's a bit of a different vernacular.

Linda Katz: There are clearly questions that need to be answered in either these regulations or another set of regulations.

Jennifer Bowdoin: Let's do this. If you have things that were not raised today, come see us, email us, and somehow get us your information. We will try to make changes and get them back out. If you are interested in getting more engaged to get these out, email us and we will give thought

to see how best to address that need.

Maureen Maigret: In the rate setting process, for those beneficiaries who meet hospital level of care and therefore will get HAB services, would those beneficiaries have a higher capitation rate set for them?

Michelle Szylin: Yes they do. We compare their community based services to the hospital cost instead of the nursing home costs.

Jennifer Bowdoin: Yes but on the managed care cap rate that is different – in RHO for example we have different rates for those receiving Long Term Services and Supports or Medicaid only, and then if dually eligible it is broken down further. We end up doing a population level rate setting for those broken down groups. The rate setting process is generally pretty good – population level so always some level of error in there. There are other financial provisions, risk corridors for risk and gain share provisions, those exist within contractual requirements. When the three way contract is available you will be able to see that.

Jim Nyberg: When will that be available?

Jennifer Bowdoin: We are still negotiating. Hopefully really soon, but it would be difficult to give a clear date as we do not have full agreement on everything. Once contract is signed, CMS will take some time to officially approve it; at this point it should be quick, but the feds to have to look at it and take a few days to execute.

Virginia Burke: In the ICI Phase II – people would be auto enrolled and have the right to opt out. In this year's budget there is a section to say enrollment mandatory. These regs seem to imply still opt out available.

Jennifer Bowdoin: There is a state law that prevents us from requiring managed care plans for anyone receiving Long Term Services and Supports. If that law changes that removes that barrier. There is another law if you require mandatory enrollment in managed care, CMS requires you to provide choice. As we just have NHP in this arena, we would need to get a federal waiver for that. So for the foreseeable future there is no mandatory managed care. The state has always had an interest in moving populations into managed care and that has not changed, but nothing we can do in the near term.

Marjorie Waters: On the federal level are you actively seeking change?

Jennifer Bowdoin: Some discussions last summer but nothing recent – the state may pursue it someday but there are no current proposals.

Jim Nyberg: The regulations on that for Phase I are pretty clear, but Phase II regs for opt out seem fuzzy – may need to clarify.

Jennifer Bowdoin: We can look at that, but it is because of the demonstration rules, and we have to comply with fed rules. Operational challenge but we can work on trying to clarify some of the language.

Ann Mulready: In here for the first time there were several references to medical necessity, but it is not defined here. That would be very helpful to include that definition.

Jennifer Bowdoin: That's an easy change we can add the definition. We will keep this on the agenda for the next ICI Council meeting.

Nicholas Oliver: The timeline as it currently stands if everything was secured, July 1 implementation, May 1 letters go out?

Jennifer Bowdoin: The demonstration start date is dependent on several milestones – the big one to get past is signing a contract. The earliest effective enrollment date will be no sooner than July 1 2016. That means 35 days prior to anyone being eligible for enrollment we will send the first letters which will be an opt in letter. It will depend a little bit on our connectivity with CMS, it will likely change our numbers a bit, but we are looking at about half the pop being targeted for opt in enrollment. The plan is to split those two groups for opt in earliest effective date July 1. Second opt in wave starts a month after that. That puts us around May 25/May 26 to drop the first letters. People would have to enroll by June 10 to have coverage July 1. We are anticipating about 10% will actually take an active step to enroll but I wouldn't expect to see them all July 1.

Linda Katz: I am sorry to raise this, but all of these folks are rolling out of InRhodes and into UHIP. Some may have a UHIP account some won't. Has there been discussion around the timing about sending these notices to people as when the state sends notices about Bridges?

Jennifer Bowdoin: That is a concern. The enrollment of this program happens in MMIS not in Bridges so that helps. It is of course something we are looking at – at this point there is not plan to delay the start of the demonstration because of UHIP but it doesn't mean that it may not change. Because the first groups are opt in enrollment groups who need to take an active step the concerns are a little lower but we do see that and want to plan for it. We have eight enrollment waves. We have a lot of flexibility that if we need to adjust that, if we need to delay, we can move that enrollment schedule if we need to – certainly delaying passives is an option. The passives the first letter has to go out between 60 and 90 days so the longer delayed, the longer push back for that program.

Linda Katz: Right. You all have been responsive on community input on letters and I haven't seen the Bridges letter yet, but I think having input on both of those letters would help a lot.

Marjorie Waters: And the silos disappear once the letters are in the community as folks show one to another and there is confusion.

III. The ICI Implementation Council – Transition Updates

Jennifer Bowdoin: Working to transition this group into formal body with formal membership and consumer participation. We have a draft charter, we have an outreach letter to recruit membership and a brief FAQ to

explain. We will schedule some info sessions if people are interested to come and ask questions, we will try to kick all of this off really soon, and then try to get a good representation of the populations affected. The intent is to have it be consumer led and driven, though not all members will be consumers: 51% will be consumers/caregivers, and looking at total 15-21 members. We would love for you all to help us get people who may be interested to be involved. Any mailing lists or groups you want us to send to is welcome. We know we need to provide transportation and stipends to be successful and we are working on it; we are pretty sure on the transportation side, but we are a little less sure on funding for the stipends, so we want to be careful about that. We recognize the importance and are trying to figure it out. Those will be coming out very soon and we will schedule an implementation session.

Linda Katz: Can you give an update on the Ombudsman program.

Jennifer Bowdoin: We issued the RFP, that period has ended, we have one bid we are in the process of reviewing and hopefully in the near future. Working on training materials to have ready when and if a decision is made, also reporting requirements etc. As a number of other states went before us we are in good shape.

Virginia Burke: The ICI Phase II is supposed to generate every six month reports – is there one in the near future?

Jennifer Bowdoin: Yes there is – it will cover the two six month periods in 2015. We have a report that has both, and a cover letter, looks similar to what was produced in the past. We want to make that report more useful and beneficial in the future. This is a report on Long Term Services and Supports expenditures, but we have other reporting that happens we may be able to pair with it.

IV. Public Comment

V. Adjourn